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ABSTRACT

This document reviews how schools and providers of school-based mental health programs have implemented managed care contracts with Medicaid managed care organizations. Observations were made at three sites (Albuquerque, NM; Baltimore, MD; New London, CT) where school-based mental health services were provided by Medicaid organizations. Following background information, the methodology used to explore policy options is discussed. Four main conclusions can be drawn from the experiences of the three study sites: (1) better understanding of the interrelationship between community-based mental health services and school-based mental health services is needed; (2) lack of on-site support makes implementation difficult; (3) prevention-oriented services are covered in only a few instances; and (4) better coordination is needed between agencies and school-based mental health services. Other models for including school-based services are also reviewed. A discussion is included on financing and reimbursement issues that may affect viability and expansion of services. Consideration is given to alternative ways to maintain and expand services. (JDM)

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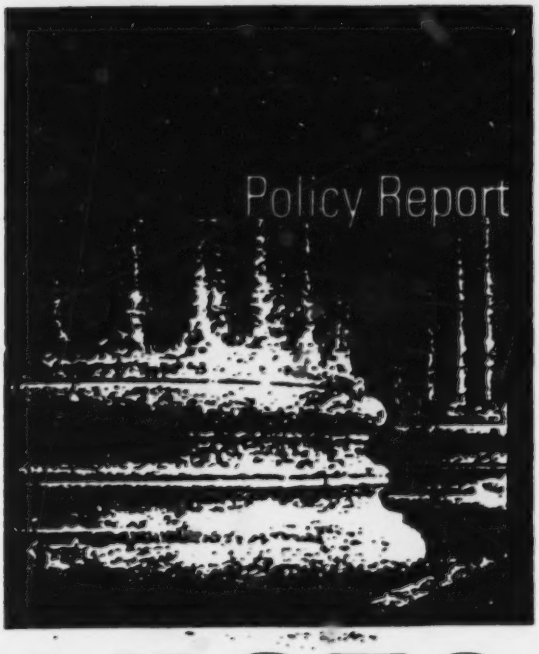

SCHOOL-BASED MENTAL HEALTH SERVICES *under* MEDICAID MANAGED CARE

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Policy Report

SCHOOL-BASED MENTAL HEALTH SERVICES *under* MEDICAID MANAGED CARE

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Table of Contents

I. Executive Summary v

II. Introduction and Background 1

III. Methodology 7

IV. Study Findings 11

V. Conclusions and Recommendations 17

VI. Appendix A: Advisory Panel Members 19

VII. Appendix B: Site Visit Reports 21

B-1. Albuquerque, New Mexico 21

B-2. Baltimore, Maryland 29

B-3. New London/Groton, Connecticut 36

VIII. Appendix C: References 43

List of Tables and Exhibits

Table 1:	Study Respondents	10
Exhibit B-1-1:	School-Based Health Timeline	22
Exhibit B-1-2:	Pilot Administration	23
Exhibit B-1-3:	Contractual Relationships	25
Exhibit B-2-1:	Flow of Paperwork for Reimbursements and Prior Authorizations	32
Table B-2-1:	Funding for School-Based Mental Health Services in Baltimore	33
Exhibit B-2-2:	Flow of Dollars from the State Level to the City and School Level	34
Exhibit B-3-1:	CFA Structure	38

Executive Summary

This study sought to learn how schools and providers of school-based mental health services work with Medicaid managed care organizations. To that end, it observed the experiences of several States and local communities in providing for the inclusion of school-based mental health services in managed care contracts. The study also explored options and models for including school-based mental health services within managed care; examined financing and reimbursement issues that might affect the viability and expansion of such services; and assessed alternative ways to maintain and expand school-based mental health services within the managed care environment.

A multidisciplinary team with experience in mental health, school health, and health care financing conducted the study. Site visits were conducted in three states: New Mexico, Maryland, and Connecticut. The chosen sites had well-established school-based mental health programs and were actively implementing managed care contracts with local Medicaid managed care organizations (MCOs).

The study revealed that providers of school-based mental health services and administrators of the programs struggle to solve numerous logistical and administrative problems that are inherent to the startup of new business arrangements for service delivery, service coordination, and reimbursement. The partnerships between school-based programs and managed care organizations are relatively new. Many of the problems associated with these new partnerships are likely to be growing pains, which will resolve over time. While study respondents had doubts about the feasibility and value of contracting with managed care organizations, they acknowledged that working with these organizations brings school-based mental health programs into the mainstream of health care financing, establishes credentials of school-based providers, and improves accountability.

The main study conclusions are that school-based mental health programs need more support to effectively and efficiently implement managed care contracts, and that policy leaders should consider other options for capturing third-party insurance revenue in addition to traditional behavioral health managed care network provider contracts. Specific study findings include the following:

1. At the study sites, the sponsoring agencies for school-based mental health services successfully negotiated contracts with Medicaid managed care plans. However, these arrangements varied greatly in their complexity, ease of implementation, and

results regarding revenue generation and barrier-free access to mental health services.

2. Schools that had mental health clinicians prior to managed care still had those clinicians. Providers were not shifted into other service venues because of managed care network pressures or decisions to end school-based health center (SBHC) services. Barriers to care emerged from administrative policies, not from a loss of mental health clinicians providing services in the schools.
3. Sponsoring agencies, State Medicaid agencies, and MCOs lacked understanding about the full scope and value of school-based mental health services and the role that such services can play within the overall system of care for children. The decision to collect third-party dollars through MCOs was not grounded in carefully thought-out strategic plans consistent with the philosophical base and principles supporting school-based mental health services.
4. The implementation of managed care may have changed access to community-based mental health services and may also have changed the mix of available community-based services. This affected the demand for mental health services within the school and the level of care needed by children attending school.
5. The study team observed a number of missed opportunities for enhanced coordination between school-based mental health programs and other school health services.

Study recommendations included exploring ways to help school-based mental health programs develop the needed skill and infrastructure to implement viable managed care contracts, defining other approaches to generate Medicaid revenue for school-based mental health care, and improving coordination between school mental health programs and other school health programs. The evaluation team also identified the need for further research to understand and quantify the effects of managed care on the availability and mix of community-based mental health services, and, consequently, on the demand for school-based mental health services.

1. Introduction and Background

Whether children are publicly or privately insured, managed care is fast becoming the dominant mechanism for health care insurance. Of low-income children, 34 percent are covered by private insurance, 41 percent by Medicaid, and 25 percent are uninsured (Kaiser Family Foundation, 1999). In 1987, 92 percent of employers reported fee-for-service plans as the most prevalent plan type. By 1997, fee-for-service plans were reported as most prevalent with only 20 percent of employers; the majority of employers reported managed care plans as most prevalent (Hay Group, 1998). Similarly, by 1998 nearly 54 percent of Medicaid beneficiaries were enrolled in managed care (DHHS-HCFA, 1998).

SBHCs are recognized as first-line providers of health and mental health services to school-aged children (Making the Grade, 1998). Although certainly not universal, 45 States have these centers. In many centers, mental health care is the most frequent service sought by students. Managed care arrangements are changing the way in which school-based health services and school mental health providers interact with other providers in the health care system, and are affecting students' access to mental health services.

Managed care also influences school-based health care financing. In recent years, States, foundations, and the Federal Government have encouraged SBHCs to bill for third-party insurance to supplement their public and private grants (Making the Grade, 1998). SBHCs' ability to receive third-party reimbursement depends in large measure on their positioning under managed care. A recent report on mental health expenditures in the private sector found that while the value of general health care benefits had decreased by 7.4 percent since 1988 because of managed care, the value of behavioral health care benefits decreased by 54.1 percent (Hay Group, 1998). A financing strategy that seeks managed care reimbursement for SBHC services may have a deleterious effect on mental health reimbursement. This report presents the experiences of several school-based health programs in three States to explore how they are adapting to the managed care environment.

Report Overview

The purpose of this study was to identify and examine different options for the integration of school-based mental health services with Medicaid managed care plans. It sought to accomplish this by:

- Observing the experiences of several States and local communities in providing for the inclusion of school-based mental health services in managed care contracts.

- Exploring options and models for including school-based mental health services within managed care.
- Examining financing and reimbursement issues that might affect the viability and expansion of such services.
- Assessing alternative ways to maintain and expand school-based mental health services within the managed care environment.

The scope of the study was intended to include both school-based and school-linked mental health services. School-linked programs are housed near or on school grounds but not in schools, and school-based programs are located in school buildings. The review of the literature did not make a distinction between these program types, and our study sites did not include school-linked programs. It appears that the policy and operational issues relating to arrangements with MCOs are similar for both program options, but we were unable to make a direct comparison within the scope of this project.

A multidisciplinary team, experienced in mental health, school health, and health care financing, conducted the study. The team reviewed recent literature on the topic, formed an advisory panel to guide the study approach, and carried out site visits in three States: New Mexico, Maryland, and Connecticut. A site visit protocol was developed based on a literature review and guidance from the advisory panel, which included experts in the fields of mental health, pediatrics, education, and school health (Appendix A). The panel of experts also helped establish study site selection criteria and recommend appropriate sites. The chosen sites had well-established school-based mental health services that were actively implementing arrangements with local Medicaid MCOs. At all three sites, the actual contracting entity was the sponsoring agency for the school-based services. Most schools that offer mental health services use a sponsoring agency (i.e., a clinical intermediary) to administer and supervise the service delivery. These intermediaries usually oversee clinical practice, set practice protocols, handle communications with other health providers, and hire or recommend hiring school-based providers. In New Mexico, for example, the sponsoring agency was a medical center with outpatient and inpatient mental health programs; in Maryland the sponsoring agency was a community mental health center; and in Connecticut the sponsoring agency was a nonprofit, community-based multiservice organization.

Providers and administrators of school-based mental health programs are grappling with logistical and administrative problems related to service delivery, service coordination, and reimbursement. Many of the problems associated with new partnerships between school-based programs and MCOs are growing pains that will probably resolve themselves over time. Interviews with school staff, school-based clinicians, and representatives of sponsoring agencies, however, revealed that contracts between school-based mental health programs and MCOs are not enthusiastically endorsed as the wisest choice. Study respondents gave the following reasons for their doubts:

- The missions and philosophies of school-based mental health programs may not fit well with the expectations of MCOs.

Many SBHCs have a policy of offering prevention and early intervention mental health services to all students without determining insurance coverage or establishing a mental health diagnosis.

- Improved access to health care services through SBHCs is based on mental health services being readily available when a student recognizes a need. This strong program tradition may conflict with managed care contracting, especially when competing plans in the area do not cover the same services, or when school-based providers are not enrolled in all the plans covering the geographic area served by the school.
- Many traditional managed care provider contracts limit reimbursement to visits related to a clinical diagnosis of mental illness and treatment for an acute problem. They often do not cover the full value of SBHC services, which include teaching about self-care, coaching to reduce risk, and prevention-oriented group programs.
- Managed care requirements for prior authorization of behavioral health visits and the use of *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic codes on claims can create barriers to care for children who already are reluctant to seek mental health services and may fear loss of confidential access to care.
- Pressure to serve children covered by managed care plans may displace the SBHC's capacity to provide mental health services to uninsured children and to continue mental health programs that are not reimbursable.
- Many SBHCs lack the necessary business infrastructure to implement behavioral health managed care contracts and handle claims processing efficiently. The school-based programs are usually run with minimal staff. Clinicians do double duty as administrators; generally no one concentrates specifically on business arrangements.
- Revenue potential for school-based mental health services is difficult to estimate and predict because many variables influence whether a claim is approved and whether it actually gets processed. Once revenue is collected, it may go to the sponsoring agency or even to the State's general fund, not to the school or SBHC. It is not clear that collected revenue offsets the cost of generating it.

While these factors influence the perceived desirability and feasibility of contracts between MCOs and providers of school-based mental health services, managers and clinicians acknowledge that working with MCOs brings the SBHCs into the mainstream of health care financing, establishes the credentials of school-based providers, and improves accountability.

The main study conclusions suggest that providers of school-based mental health services need more support to effectively and efficiently implement managed care contracts and that other options for capturing third-party insurance revenue in addition to traditional managed care network provider contracts should be considered.

The remainder of this report reviews study methodology, describes study site selection, presents study findings, offers conclusions, and suggests areas for future research. Appendix B includes detailed case studies drawn from visits to the three study sites.

Background on School-Based Mental Health Services

SBHCs were established in the early 1970s with the goals of making all health care more accessible to children and adolescents and reducing the incidence of behavior-related health problems. Over the past 25 years, SBHCs have expanded to 45 States and more than 1,000 centers nationwide. Centers are located primarily in high schools but also are developing in elementary and middle schools. Most SBHCs are located in the New England and Mid-Atlantic regions (422 centers). Since 1997, the Midwest has experienced the largest expansion of SBHCs, a 61 percent increase. Most centers (63 percent) are concentrated in urban areas, but growth into rural areas is increasing. In 1998, 26 percent of centers were in rural areas (Making the Grade, 1999).

Services offered at SBHCs include an array of primary medical care, public health, and mental health services, including basic physical exams, age-appropriate screening tests, health education, and treatment of minor illnesses. Mental health services generally include comprehensive individual evaluation, case management, individual and group therapy, crisis intervention, and basic drug and alcohol prevention and treatment services. Some centers provide family counseling. A survey of 405 SBHCs in 1996 found that 17 percent of visits to SBHCs were for mental health concerns. Eighty percent of SBHCs offered crisis intervention, 70 percent offered individual evaluation, 62 percent offered preventive mental health services and 57 percent offered individual treatment. Urban centers were more likely to provide comprehensive mental health services than rural centers (Advocates for Youth, 1998).

Center staff usually includes part-time physicians, nurse practitioners or physician's assistants, nurses, social workers, and mental health providers. Some centers also have health educators and nutritionists. In some centers the school nurse is part of the center staff, while in others he or she is a school employee and coordinates with the center. In the 1997/1998 Making the Grade survey of SBHCs (Making the Grade, 1999), 57 percent of responding centers reported a full-time primary care provider on site. Data available on mental health providers in schools was reported by school districts, not by SBHCs. Fifty-five percent of schools had counselors, 40.5 percent had psychologists, and 21 percent had social workers (Davis, Fryer, White, & Igo, 1995).

Mental health services delivered in schools are sometimes integrated with and sometimes separated from SBHCs, or sometimes are located in schools that do not have an SBHC. For the freestanding school mental health services, schools usually make arrangements with providers from community mental health centers or outpatient facilities to provide part-time services in the schools. Often schools will employ mental health providers such as school psychologists and social workers as part of their special education programs. These providers usually are not available to the general student population. Such variations in service delivery affect which students in the school have access to which services. Multiple methods for delivering mental health services within each school carry with them the potential for service duplication but also create opportunities for service coordination and integration.

School-based mental health programs traditionally have a mix of funding sources, with heavy reliance on State general funds,

private foundations, and Federal grants. Thirty-seven States and the District of Columbia helped to fund at least some of the centers. Funding from third-party insurance reimbursement is increasing. Medicaid fee-for-service, Medicaid managed care, commercial insurance revenues, and Child Health Insurance Program (CHIP) outreach were reported by schools as sources of revenue (Making the Grade, 1998). Fifteen States reported Medicaid fee-for-service revenue, five reported Medicaid managed care revenue, and seven reported commercial insurance revenue.

State policy increasingly enables SBHCs to collect third-party revenue. Forty-three States allow SBHCs to bill Medicaid and CHIP. Only three States (Arizona, Hawaii, and Oklahoma) prohibit Medicaid billing, and those three States plus North Carolina do not allow SBHCs to bill CHIP. Twenty-two States report that at least one SBHC in their State signed a managed care contract, while 23 States plus the District of Columbia report no SBHC/managed care contracts. State policy supports SBHC/managed care contracts to varying degrees. Twenty-eight States report encouraging SBHC participation in Medicaid managed care (Lear, Eichner, & Koppelman, 1999). According to a 1997 review of State Medicaid agency contracts with managed care organizations, 13 State contracts contained provisions related to relationships between managed care plans and SBHCs, and, of those, two States specifically addressed mental health services in schools (Rosenbaum, Silver, & Wehr, 1997).

III. Methodology

The development of SBHCs and the delivery of mental health services within the centers has been a community-driven process, with each center striving to meet the unique needs of its students and community. Centers must be responsive to the expectations of school boards, school administrations, and health care and community leaders. This history creates variety in school-based health center designs and operations. The evaluation team was challenged to account for SBHC variation in the study design and produce a report useful to a majority of programs. The study explored policy options at the national and State levels and addressed practical questions for schools and operating SBHCs. The study focus included the following:

- Collecting information about changes in school-based mental health services, client mix, and service utilization following implementation of Medicaid managed care.
- Observing how school-based mental health services fit within the overall health care system.
- Questioning study participants about the impact of Medicaid and MCO policies and procedures.
- Gathering suggestions about feasible options for including school-based mental health services in Medicaid managed care contracts.

Major components of the study methodology are described in the balance of this chapter.

Literature Review

The search for relevant literature drew upon recent studies from the fields of health, mental health, education, and health care financing. Making the Grade, an SBHC national technical assistance center, funded by the Robert Wood Johnson Foundation; the National Assembly on School-Based Health Care; and the Centers for School Mental Health Assistance, funded by the Bureau of Maternal and Child Health, Health Resources and Services Administration, DHHS, were rich sources of historical and current information. A 1998 survey of SBHCs released by Making the Grade provided State SBHC comparison information on service utilization, providers, and funding sources. Additionally, several health and social science databases were searched, among them Dialog, Medline, and Healthstar. In the initial summary of

reviewed literature, information was presented on access to and utilization of school-based mental health services, SBHC experiences with managed care contracts, and financing of SBHC. This information was then used to refine the research questions and shape site visit protocols. Specific findings from the literature review include the following:

- The range of mental health services offered at SBHCs varies considerably from center to center. However, the majority of SBHCs offer crisis intervention (80 percent), case management (71 percent), comprehensive individual evaluation (70 percent), preventive mental health programs (62 percent), and comprehensive individual treatment (57 percent).
- Adolescents enrolled in a managed care plan with access to an SBHC were more likely to make a mental health or substance abuse–related visit to the SBHC than those without access to an SBHC.
- Currently, 28 percent of SBHCs have formed relationships with managed care entities. The roles SBHCs adopt vary considerably, but generally can be categorized into one of three types of arrangement: full primary care provider, specialty care provider, and co-manager of primary care.
- There are considerable communications and legal obstacles to overcome before SBHCs and managed care entities can work together successfully. Since few free-standing SBHCs have the experience or authority to negotiate with health plans, they may be reluctant to pursue relationships with managed care entities.

Several themes drawn from the literature had particular implications for study design:

- Mental health services are among the most frequently used services in SBHCs; SBHCs provide important points of access to mental health services, since they are perceived by students as presenting fewer barriers to care than traditional mental health settings. Such characteristics as immediate availability of care, confidentiality of services, and student-centered providers are important service aspects that are different from other service sites. The current study was careful to assess how managed care plans understand and accommodate these unique aspects of care.
- State Medicaid policy ranges from mandating that Medicaid MCOs contract with SBHCs, to requiring coordination between Medicaid MCOs and SBHC, to simply encouraging coordination. SBHC contract arrangements seem to group into three categories: SBHCs are contracted with as primary care providers, ancillary or specialty providers, or primary care co-managers in partnership with a network provider. When selecting sites for the study, the diversity of requirements and contracting practices was taken into consideration.
- Information about other approaches to financing SBHC and mental health services in schools is very limited in the literature. Site visit protocols therefore were designed to elicit information about innovative financing and managed care strategies that may be developing in the field.

Advisory Panel

An advisory panel to the project was established to help guide the scope of research, critique the study design, and advise about appropriate sites for data collection. The panel included nationally recognized leaders in the fields of mental health, adolescent health care, education, Medicaid, public health, and several advocacy or technical assistance groups experienced in school-based health care. The group convened in February 1999, after the release of the project literature review. Criteria for selecting the study sites were discussed, and practical advice about the scope of the study was elicited. The advisory panel strongly suggested that the study be designed to provide practical information to programs and State agencies to begin or enhance the process of connecting managed care and school-based mental health services. Advisors also encouraged developing the report as a tool to help educate State officials and MCOs about the value of mental health services in schools.

Site Visit Protocol and Study Site Selection

Site visit protocols were designed to gather data from a wide array of informants and vantage points across the health system. Preliminary telephone interviews included State Medicaid and public health officials and representatives from Medicaid managed care plans. On-site interviews included school administrators, school nurses, SBHC coordinators and providers, representatives from managed care plans, staff or providers from SBHC-sponsoring agencies, and, in some cases, other school staff such as school psychologists and counselors. At some sites, perspectives from teachers, students, and parents were also gathered. The protocols were designed to gather descriptive data about the structure of school-based services, the arrangements with MCOs, and qualitative data about the experiences of respondents at different points in the service system.

Study site selection was based on four criteria:

1. Sites with different types of managed care programs, such as fully capitated integrated health and behavioral health plans, partially carved-out behavioral health plans, and plans that subcontract with behavioral health care networks.
2. Sites with formal agreements in place between SBHCs and managed care organizations with at least 1 year's experience with managed care.
3. At least one site in which the State Medicaid agency requires plans to contract with SBHC.
4. At least one site in which the school or educational system is heavily involved in and funds the SBHC.

Possible candidate sites included California, Colorado, Connecticut, Maryland, Massachusetts, North Carolina, and New Mexico. Final site selection was based partially on practical considerations such as the availability and willingness of the State and local SBHC to participate in the study. The selected sites were the following:

- **Albuquerque, New Mexico**
  This site was selected because of its collaborative pilot program, involving Medicaid, the State health department, and school districts, to develop and demonstrate the delivery of mental health services in schools within managed care arrangements. The educational system was also strongly committed to school-based health care. Medicaid managed

care arrangements in this State were such that schools had to work with several competing plans, which helped explore the complexities of implementing multiple contracts for each SBHC.

- **Baltimore, Maryland**
  This site was selected because of Baltimore's historic commitment to school-based health care, the role that the State mental health administration played in organizing managed care mental health services, and the inclusion of the administrative services organization (ASO) in the system. An ASO is a third party that carries out certain administrative functions under contract with the health insurance purchaser or State agency; for example, in Baltimore, the ASO handles claims processing and requests for prior authorization of services.
- **New London/Groton, Connecticut**
  This site was selected because the State Medicaid agency and the State health department both required SBHCs and managed care plans to contract with each other. These State entities were actively involved in monitoring the progress of the contracts and facilitating solutions to implementation problems. The specific site was sponsored by a community agency with a long history as a provider of community-based mental health services, different from other sites that were sponsored by medical or public health agencies.

Several types of respondents at the respective sites were interviewed. Table 1 summarizes both the number and types of interviewees who provided information detailed in the case studies.

Table 1: Study Respondents

Type of Respondent	*NM*	*MD*	*CT*	*Total*
State/local officials	3	6	4	13
School-based/linked mental health staff	4	3	7	14
Other school-based/linked clinic staff	5	2	2	9
School representatives (principal, teachers, etc.)	5	6	3	14
Sponsoring organization officials	2	–	1	3
Managed care organization representatives	1	1	–	2
Total	20	18	17	55

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IV. Study Findings

This chapter presents crosscutting findings drawn from the study sites that suggest options for both national policy and action to support school-based mental health services. Appendix B includes detailed site visit case studies containing information and suggestions from the individual experiences of each site and its study participants. The case studies will help readers understand the complexity of day-to-day SBHC and school health operations. They also may help inform centers and programs about potential solutions to problems or innovative approaches. A synthesis of study findings follows:

1. **At the study sites, sponsoring agencies for school-based mental health services successfully negotiated contracts with Medicaid managed care plans. However, these arrangements varied in complexity, ease of implementation, and results regarding revenue generation and barrier-free access to services.**

- At all three study sites, contracts with managed care organizations were undertaken by the SBHCs' sponsoring agencies. The agencies also were employers for the mental health clinicians who offered primary mental health services at the schools.[1] This arrangement relieved school-based staff and school of the burden of negotiating managed care contracts directly. Moreover, it meant that SBHC services were defined in the same terms as the other clinical services provided by the sponsoring agency. Sponsoring agencies did not negotiate for coverage of the full range of SBHC services, arrange for different administrative procedures for SBHC providers, or consider different reimbursement rates.
- Because the sponsoring agency and the MCO tended to treat school-based mental health programs the same as other community-based mental health providers, reimbursed services generally were limited to diagnosis and therapy claims using customary diagnostic and procedures codes. None of the study sites used the newly defined mental health primary care diagnostic codes of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, primary care version (American Psychiatric Association, 1995). This approach did little to ensure that students would have open access to services, one of the hallmarks of the SBHC. The emphasis on traditional therapy did not permit full

[1] In New Mexico the sponsoring agency was a medical center with outpatient and inpatient mental health programs; in Maryland the sponsoring agency was a community mental health center; and in Connecticut the sponsoring agency was a nonprofit, community-based multiservice organization.

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exploration of arrangements to cover preventive mental health services such as health promotion and risk reduction, early identification of problems, and early intervention. Some emerging efforts to cover preventive mental health services were disclosed by participating sites. For example, in Maryland, agencies at the city and State levels were collaborating to develop arrangements for preventive mental health services within managed care. In New Mexico, one of the behavioral health MCOs had opened a dialogue with schools and school-based providers to consider innovative service arrangements, expressing the belief that SBHC had great preventive potential. Contracts had not yet been expanded, but the plan did allow self-referral and open access to primary mental health visits at the school.

- At all three study sites, providers and school-based mental health program staff reported that administrative procedures required by managed care plans were burdensome and that compliance was time-consuming. These burdens—such as obtaining prior authorization for mental health visits, submitting mental health treatment plans, submitting claims, and meeting provider credentialing requirements—are the same as those experienced by community-based mental health providers. However, SBHCs had fewer on-site resources and less robust infrastructure to support the new administrative requirements. In New Mexico, the complexity of the system, with three managed care plans and two behavioral health plans, created numerous implementation problems. Maryland and Connecticut also reported problems learning about and efficiently carrying out managed care provider requirements. In Maryland, SBHCs had only one entity with which to work—the statewide management service organization—but they still had responsibility for registering students, requesting prior authorization for services, and producing claims for each visit.
- Involvement of SBHC and school-based mental health clinicians with managed care, coupled with pressure from funding agencies to collect third-party revenue, pushed SBHCs into new roles. Sites reported that they had to establish new mechanisms to determine the insurance status of students and to help enroll students in Medicaid or CHIP. At several sites, school staff—such as the school nurses—also were engaged in this "outreach" activity. While such outreach is well within the scope of most SBHCs, mental health programs were not staffed for the activity; clinicians found themselves diverting time formerly available for clinical services to undertake outreach.

2. **School-based mental health clinicians continued at that site following adoption of a managed care contract. Providers were not shifted into other service venues because of either managed care network pressures or decisions to end SBHC service. Barriers to school-based mental health care emerged from administrative policies, not from a loss of clinicians within the school.**

- School-based providers and administrators did not report a loss of clinicians working in schools. In New Mexico, at least one SBHC obtained a new clinician when one of the MCOs assigned a provider to practice in the school. In Maryland, the administering agency for the Medicaid mental health managed care plan—Mary-

land Mental Health Administration—opened up Medicaid certification to new classifications of mental health providers, including licensed clinical social workers. This both expanded the provider network available to Medicaid-eligible children and enabled SBHCs to recoup revenues for some of their providers who were previously excluded from reimbursement.

- Although provider presence in schools remained relatively steady, all three study sites reported a decrease in the amount of time available to see students because of new administrative demands. The most frequently reported problem: obtaining prior authorization for services. With some plans, the process could take as long as an hour for each student. In Maryland, extensively documented treatment plans were required; in Connecticut, one plan required the SBHC physician to make the prior authorization request rather than support staff. Some plans permitted a limited number of visits (ranging from 2 to 12 visits in our study sites) without authorization or with a simplified request. This eased initial access concerns but did not eliminate the problem.
- SBHCs and providers reported that increased pressure to join Medicaid managed care networks and generate third-party revenue shifted provider time to Medicaid-covered children, with less time for both uninsured and privately insured children. This tension will exist as long as service demand in schools exceeds provider availability. Clear funding streams for services for uninsured children can help address this concern.
- For the most part, SBHCs, schools, sponsoring agencies, and managed care plans created small, local problem-solving and coordinating groups to address the administrative and implementation problems affecting access to care. New Mexico had an interagency group as part of its pilot project. In Maryland, the city health department and management services organization worked together to negotiate new procedures. The degree to which State agencies encouraged the problem-solving approach varied. In Connecticut, both the State Medicaid agency and the State health department were very active in helping local groups find ways to reduce barriers to care.

3. **Sponsoring agencies, State Medicaid agencies, and managed care organizations did not appreciate fully the scope and value of school-based mental health services and the role such services can play within the overall system of care for children. The decision to collect third-party dollars through MCOs was not grounded in carefully considered strategic plans consistent with the philosophy and principles of school-based mental health programs.**

- This insufficient understanding was evidenced by MCOs and by SBHC-sponsoring agencies, which generally treated SBHC providers like any other provider of outpatient mental health services. On the positive side, these arrangements with managed care brought SBHCs into the mainstream of health care financing, strengthened SBHC provider credentials, and enhanced service documentation and accountability. On the negative side, the emphasis of managed care arrangements sometimes conflicted with the philosophy of SBHCs that emphasizes barrier-free access by

students to services, with an emphasis on prevention and early intervention. Study respondents reported concern that revenue generated through managed care might not offset some of the negative results.

- At study sites, State public health departments and State Medicaid agencies did not help SBHCs, sponsoring agencies, or managed care organizations develop other approaches to managed care contracting, such as subcapitation or global fees for prevention packages. SBHC managed care contracts did not draw financing from managed care budget lines other than provider network budget lines. The use of managed care community health promotion or member support budget lines, instead of provider network contracts, had not been explored. Development of such cost alternatives might have reduced the administrative burden on centers and eliminated some of the implementation problems, while accomplishing plan and center objectives. Study sites each had some processes in place to help demonstrate the value and feasibility of some of these alternative arrangements.

4. Implementation of managed care may have changed access to community-based mental health services, including inpatient care, and also may have changed the mix of available community-based services. This, in turn, affected the demand for mental health services within the school and the level of care needed by children attending school.

- Both New Mexico and Connecticut reported a trend toward keeping students who are suffering from severe mental health problems in school. Study respondents believed this was related to decreased availability of day and residential treatment services in the community and/or tight prior authorization requirements for more extensive treatment services. In New Mexico, several inpatient treatment facilities had closed following implementation of Medicaid managed care. With fewer deep-end services available or accessible, school-based providers reported greater demand for school-based treatment of serious mental health problems.
- Extensive efforts by school-based providers to get managed care authorization for inpatient or day treatment often were to no avail. As a result, some providers felt they had no choice but to continue to provide care for students in the school until community-based arrangements could be made. For example, one SBHC clinician provided daylong supervision for a suicidal student since no other treatment was available. The transfer of care from community provider to school caused strain on the entire school system and shifted services in the school away from prevention. Although this finding is preliminary, the potential seriousness of the problem indicates a need for further study and confirmation of the extent of the problem.

5. A number of opportunities have been missed to enhance coordination between school-based mental health program agencies and other school health programs.

- In two study sites, managed care arrangements for school-based mental health services and school-based health services were separate and uncoordinated. In New Mexico, the sponsoring agency for the mental health services had arranged

contracts for SBHC, but other health care services were not covered by managed care plans. This was related to the fact that different managed care organizations were involved and also that the sponsoring agencies for medical services and mental health services/providers were different.

- In contrast to the inadequate coordination of contracting with managed care organizations, individual physical and mental health care on site at schools more often than not was integrated. SBHCs held regular multidisciplinary team meetings and clinical treatment plan reviews. Study respondents reported extensive efforts to coordinate care among center clinicians and also to coordinate care between center staff and school staff—such as teachers, school counselors, school nurse, and school special education staff. Providers at schools did report some instances of disrupted communications between community providers and schools. This seemed to be a product of changes in communication because of managed care prior authorization requirements and the need for both entities to learn how to work with managed care staff. These concerns were judged by respondents to be start-up problems that could be resolved locally.
- In our study sites, several opportunities to coordinate and integrate other school health services with the SBHC were not fully realized. Schools acted as hosts to the SBHCs and/or school-based mental health providers and were not actively involved in negotiating managed care contracts or processing third-party claims. With the historic autonomy of local school districts, each school district and local school board decides individually how it will participate in school-based health care, but generally leaves service delivery management to a sponsoring health care or behavioral health agency. In all three study sites, school arrangements for Medicaid (under EPSDT) coverage of school nursing services and health-related special education services were separate from SBHC. While the pros and cons of combining these arrangements are not yet fully understood, key potential advantages are a reduction in administrative burden for SBHC programs and a more comprehensive system of care for children. While EPSDT school arrangements are being used by schools to generate revenue, it is worth considering how EPSDT might be used to strengthen the connection between mental health and other health services in the school and to integrate both with community-based health care. Another unrealized opportunity for coordination is the opening of SBHC services to teachers and school staff as an employee benefit. Such an option could generate a new funding stream for both mental health and other school-based health care.

V. Conclusions and Recommendations

Four main conclusions can be drawn from the experiences of the three study sites:

1. Better understanding of the interrelationship between community-based mental health services and school-based mental health services is needed. Changes in the organization and delivery of mental health services, including implementation of Medicaid managed behavioral health care, are altering the availability of mental health services in the community. Such changes are affecting the demand for mental health services in schools.
2. SBHCs may have difficulty implementing managed care organization contract requirements, primarily because of insufficient on-site support. SBHCs, sponsoring agencies, and school-based mental health clinicians appear to need more support to handle requirements for documenting credentials, negotiating rates, claims processing, and following prior authorization and record-keeping procedures.
3. In only a few instances were SBHC prevention-oriented mental health services covered by managed care contracts. Contracts generally covered only diagnosis and treatment of acute mental illness. Study respondents suggested that Medicaid incentives, through contracting or financing mechanisms, could encourage the inclusion of prevention-oriented mental health services in managed care contracts with SBHCs.
4. Many opportunities exist for enhancing coordination across the agencies and constituency groups involved with school-based mental health services. Better coordination might better ensure a comprehensive nonduplicated system of care for children that works financially and administratively.

Recommendations for Future Study

Based on study findings, the following areas of inquiry appear to warrant further examination:

- *The impact of managed care and provider network changes on children's access to community-based mental health services, and the extent to which intensive treatment of severely ill children is being shifted to school-based providers.* The hypothesis is that a reduction in the number of inpatient and residential providers, coupled with restrictive prior authorization procedures that block admissions to facilities, have resulted in increased barriers to care. The impact of these apparent changes on children and schools needs to be described and quantified further, to foster improvement in the system and to ensure that children receive needed and appropriate mental health services.
- *An audit of school-based mental health programs' managed care arrangements, to*

assess if the relative benefits of collecting third-party revenue outweigh the administrative investment. The third-party revenue being generated by SBHCs is not currently a significant source of funding, and the centers do not predict that they will be self-sustaining. This is partly because implementation problems prevent centers from successfully collecting payment for legitimate claims. It is also due to the fact that centers provide mental health services not typically covered by insurance, and because they serve uninsured children. Such an audit might help centers to design feasibility assessments and develop business plans before making the decision to move into a managed care arrangement.

- *Methods and options designed to integrate or coordinate school-based mental health programs and EPSDT/special education school arrangements.* Such integrated services are one way to build a system that supports the full value of SBHC services without forcing centers into the "medical model" prevalent in traditional managed care contracting. A study could identify benefits and drawbacks of such options, and delineate the constraints to implementation.
- *Possible development of support structures for the implementation of school-based mental health program managed care arrangements.* Ideas to be explored include the creation of regional technical assistance resource centers to help local communities solve community-specific implementation problems, and the development of local problem-solving "user groups" that can help local programs identify and solve implementation problems. Another idea for consideration is the development of regional "management services organizations (MSOs)" and networked groups of SBHCs, which would provide business services for SBHCs and for sponsoring agencies that lack the capacity to negotiate and implement managed care contracts.

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VII. Appendix B: Site Visit Reports

Appendix B-1
Albuquerque, New Mexico

I. Introduction

The Albuquerque Public School (APS) Medicaid managed care pilot for school-based/linked mental health services began in 1998 as an attempt both to increase the resources available for school-based care and to expand the size of the managed care network for behavioral health organizations. The following case study documents the experiences of two schools that participated in the pilot during the 1998–99 school year. The first section reviews structural components of the program. Following this description is a review of participants' experiences with the program to date. This review incorporates the perspectives of State and local officials, a managed care representative, mental and physical health care providers, and numerous school staff, including principals, teachers, and guidance counselors.

II. Structure

A. Background

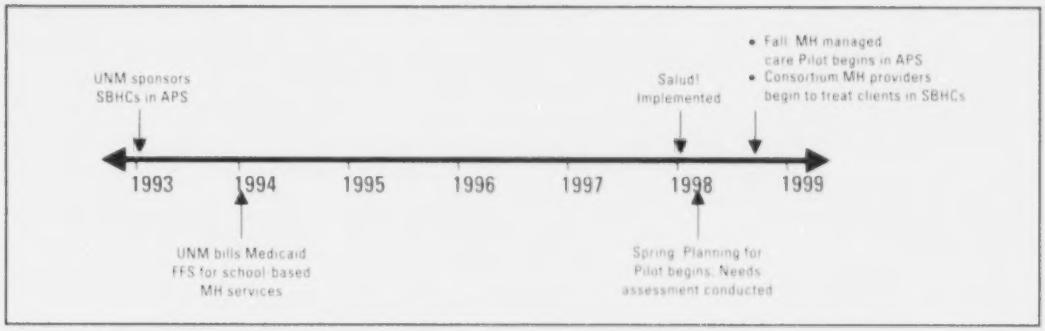
The APS district is the 27th largest independent school district in the Nation, with an enrollment of nearly 90,000 students. It comprises 11 high schools, 24 middle schools, 78 elementary schools, and 6 alternative high schools. School-based/linked health care was introduced to the district in 1993. Currently there are nine school-based health centers and two school-based/linked primary care programs operating in the APS system.

The University of New Mexico (UNM) played a large role in facilitating expansion of school-based/linked services in the APS system. The UNM School of Medicine began a community-based program in 1993, including the creation of satellite clinics within APS. The satellite clinics, or school-based health centers, offer a range of services, including primary physical health care and mental health treatment.

Financing and administration of school-based mental health care in UNM-sponsored school-based health centers have undergone substantial changes over the past 6 years. The changes were precipitated, in part, by implementation of New Mexico's Medicaid managed care program—Salud! UNM began accessing Medicaid reimbursement for many of the mental health services provided in the schools in 1994 (Exhibit B-1-1). For the first 3 years of billing, UNM billed Medicaid directly on a fee-for-service basis. The university also relied heavily on funding from its outpatient mental health center as well as State and Federal grants to finance the program.

In 1998, New Mexico implemented Salud!, its Medicaid managed care program. Salud! is a statewide capitated managed care program covering Medicaid-eligible individuals on a voluntary basis. Under Salud!, the Human Services Division (Medicaid) contracts with three health maintenance organizations (HMOs) to provide primary physical health care services to Medicaid-eligible individuals. Each HMO then contracts with a

Exhibit B-1-1: School-Based Health Timeline



behavioral health care organization (BHO) to provide all mental health and substance abuse services. In the Albuquerque area, the BHOs contract with Regional Care Centers (RCCs), including the University of New Mexico and the Consortium, a group of six community providers.

Shortly after the implementation of Salud!, one of the BHOs (Options)[2] approached the State Department of Health, Office of School Health, with a proposal to initiate a pilot program in mental health managed care within a cluster of Albuquerque's school-based health centers. Options was interested in linking its Medicaid managed care mental health services directly to school sites. APS and the State Department of Health selected five schools within the Albuquerque High School cluster as the initial pilot sites. The decision was based on results of an assessment as well as on the recognition that there are a disproportionately high number of Medicaid-eligible students attending school within the cluster. During the 1997–98 academic year, approximately 500 children enrolled in the APS SBHCs were Medicaid-eligible.

The pilot was implemented concurrent with the 1998–99 academic school year. It includes participation by all three HMOs/BHOs and their corresponding providers. Under the pilot, UNM no longer is the sole provider of school-based mental health services. Social workers from either UNM or the Consortium are assigned to work within the SBHCs and provide individual, group, and family therapy.

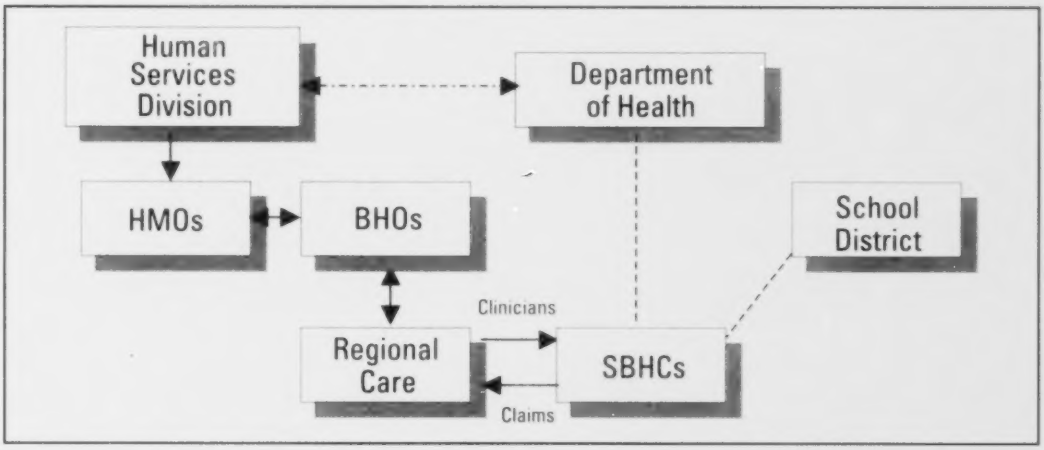
B. Administration

The mental health Medicaid managed care pilot is currently operating in five Albuquerque public schools, including one high school, one middle school, and three elementary schools. Three of the schools provide mental health services in addition to primary physical health care services within SBHCs sponsored by UNM. The other two schools do not have SBHCs and provide only mental health services.

A variety of State and local actors collaborate to administer and manage the pilot program. At the State level, both the Human Services Division (Medicaid) and the State's Department of Health have regulatory oversight of the program. Medicaid manages the

[2] Since interviews for this report took place, changes have been made in Salud! administration. Value Behavioral Health is no longer the subcontractor for the Cimarron Health Plan (CHP). CHP has created an internal behavioral health care department to manage all mental health and substance abuse services for the plan.

Exhibit B-1-2: Pilot Administration



HMO/BHO contract, while the Department of Health sets policy with respect to general operation of the SBHCs. At the local level, the APS district hosts SBHCs operating within their jurisdiction and is involved in planning and general oversight of the program. Regional Care Centers (UNM and the Consortium) contract with the BHOs and provide mental health clinicians to treat children who are registered with the SBHC. The RCCs are also responsible for submitting claims to the BHOs for reimbursement. Exhibit B-1-2 shows the relationships among the agencies involved in the program.

C. Access

Mental health services available under the pilot include individual, family, and group therapy; case management; and behavior management services. These services are provided by either a licensed social worker or a psychiatrist. Physical health care services within the SBHC are provided by physicians employed by the University of New Mexico and by a part-time nurse practitioner. Services offered include health assessment and physical examinations, disease prevention, immunization programs, limited on-site laboratory services, health promotion and education, and prevention programs. Although not part of the Medicaid managed care pilot, staff in the centers coordinate enrollment, diagnosis, and referral efforts.

Children in the Albuquerque Public School system who require mental health care or counseling have multiple avenues to access care in the school-based health center.[1] Any school employee may refer a child to the SBHC, or a child may refer him- or herself. If the child is not enrolled in Medicaid, the school nurse or the SBHC intake worker may presumptively enroll a child who meets the eligibility requirements.

Once the child is enrolled in the SBHC, either a social worker or a psychiatrist is assigned, based on the child's need and the availability and the special expertise of staff members. Additionally, if the child is Medicaid-eligible, the type of HMO and corresponding BHO in which the child is enrolled strongly influences staff assignment decisions. If, for example, a child enrolled in

[1] Information on the need and current utilization for mental health services within APS schools was not available.

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the Options plan presents at an SBHC, where both a UNM and Consortium provider are available, the child is more likely to be seen by the Consortium provider because a contractual relationship is in place between the Consortium and Options. If a Consortium provider is not available, the UNM provider must contact Options to obtain authorization before treating the child.

The SBHCs are open on all school days, but not all services are available every day. Each child psychiatrist and part-time social worker is available to treat children in the SBHC 1 day a week. When the schools are closed for summer vacation, services are provided off-site in the community.

D. Contracting

Contracting between HMOs/BHOs and SBHCs is strongly encouraged by the State's Medicaid office but not required. Although school health advocates lobbied to include language in the Medicaid Managed Care Request for Proposals (RFP) to mandate a contractual relationship between SBHCs and managed care organizations, the language was deleted from early drafts.

Despite omission of such requirements in the RFP, HMOs/BHOs in the Albuquerque region have initiated relationships with five SBHCs under the pilot program for mental health Medicaid managed care. However, the contractual relationships between the various HMOs/BHOs, their respective providers, and SBHCs are not consistent. Each HMO/BHO has established separate contractual relationships with the two RCCs (UNM and the Consortium), which, in turn, have established separate policies and procedures for the clinicians they provide to each of the participating SBHCs.

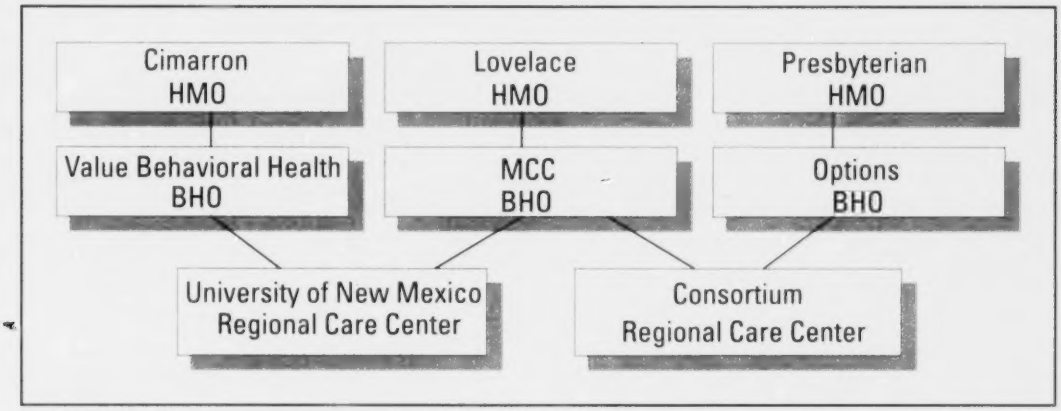
Currently, UNM contracts with two BHOs to provide mental health services in the schools, Value Behavioral Health and MCC. UNM does not have a contract with Options. The Consortium, on the other hand, has contracts with Options and MCC but currently not with Value Behavioral Health (see Exhibit B-1-3).

The contractual agreements between the BHOs and the RCCs establish UNM and the Consortium as the preferred providers, authorized to deliver services to students enrolled in the respective HMO/BHO Medicaid health plans. As preferred providers, UNM clinicians generally treat students who are enrolled in Value Behavioral Health and MCC, while clinicians from the Consortium generally treat students who are enrolled in either MCC or Options. However, these contractual arrangements do not preclude either UNM or Consortium providers from treating students enrolled in other plans. If the provider does not have a contractual arrangement in place with a plan for one of the patients it is treating, it must obtain prior authorization from the plan before proceeding with treatment in order to obtain appropriate reimbursement.

Generally, mental health providers must obtain authorization within 5 days of seeing a child. School-based clinicians must contact representatives from a child's health plan and request authorization for the type and amount of services they wish to provide. Each of the three BHOs (Options, MCC, and Value Behavioral Health), however, has established distinct prior authorization policies.

Options usually authorizes 10 outpatient sessions automatically. At the end of those sessions, the SBHC clinician must gain

Exhibit B-1-3: Contractual Relationships



authorization for an additional 10 sessions. Beyond 20 sessions, providers must submit a written justification for further treatment. MCC, on the other hand, requires both UNM and Consortium providers treating enrolled children to participate in phone interviews with a utilization review clerk to discuss the necessity for services. As with Options, 10 sessions are generally authorized initially, with follow-up requests made if the child needs further services.

Relative to the other two BHOs, Value Behavioral Health's prior authorization requirements are the most streamlined. UNM providers are not required to obtain formal authorization before treating a patient. Instead, a utilization review representative from the BHO participates in wrap-up meetings held by clinic staff and school representatives to discuss cases under their review and to decide on appropriate treatment plans. This process has made it possible for clinicians to forgo the formal prior authorization process.

E. Financing

Before pilot implementation, UNM-sponsored SBHCs received Medicaid reimbursement, private insurance, and the Healthier Kids fund (HKF),[4] a primary care fund for uninsured children developed by the State. They have also received funding from State and Federal grants, such as the Maternal and Child Health Block Grant, that were allocated to the university's Health Science Center, and funding from the UNM Department of Psychiatry for mental health services.

Under the pilot for Medicaid managed care, financial support is still obtained from a variety of sources, including direct billings to families/private insurance, capitation rates from Cimarron/Value Behavioral Health as part of UNM Programs for Children, fee-for-service contracts with Options and MCC, State and Federal grants, and UNM Department of Psychiatry faculty funds. Clinicians in each health center submit all Medicaid reimbursable claims for mental health services to their sponsoring organization, either UNM or the Consortium, that in turn submits the claim to the appropriate BHO/HMO. Reimburse-

[4] The State allocated $1 million to the Department of Health to develop a primary care fund for uninsured children. The fund is primarily used to treat children who are not yet enrolled in Medicaid but are eligible. It is also used by SBHCs to sign up many children for Medicaid.

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ment goes directly to the sponsoring organization. All school-based mental health clinicians who provide services in the SBHCs are salaried employees paid directly by their sponsoring organization.

Mental health school-based/linked services through the managed care pilot project are currently the only Medicaid reimbursable services. Similar agreements have not been forged among SBHCs, their community providers, and the Medicaid HMOs responsible for authorizing reimbursement of physical health care services.

III. Experiences

A. Administration

Clinicians at both schools found the administrative process cumbersome and time-consuming. A common complaint centered on students' enrollment; often the enrollment process can take months. Delays are blamed on paperwork lost by the MCOs as well as on family ignorance of eligibility requirements or the process. In many instances, parents are either unwilling or unable to verify the insurance status of the child. Although clinicians generally are able to identify whether or not the child in question is eligible under the contracted plan, they experience great difficulty verifying eligibility if the child belongs to a competing plan. Without accurate insurance status information, it is difficult to assign a child to the appropriate clinician and to determine the appropriate prior authorization procedures to be followed. In the interim, services provided to the child are not reimbursable and cannot be billed.

One final concern is the continual fluctuation in staffing at each of the BHOs. High turnover rates and job swapping within organizations make it difficult for clinicians and their respective sponsoring organizations to determine the appropriate contact for prior authorization, treatment planning, reimbursement, and grievance or appeal. Consequently, clinicians spend a fair amount of time calling BHO representatives to identify the appropriate contact and then must often explain repeatedly the child's relevant background information. Respondents indicated that, to date, they were never notified when staffing changes were made, nor were they ever given a list of contacts and corresponding phone numbers for the BHOs.

B. Coverage

In general, program providers and administrators were fairly positive about the range of services offered by each of the plans under the pilot. Managed care has made the availability of services more standardized across school-based health centers. In addition a greater emphasis has been placed on expanding community-based mental health care since the pilot was initiated.

Yet these community-based services do not necessarily match the need. All of the providers interviewed felt that the acuity of children's behavioral health needs has risen substantially over the past few years, citing an increased number of psychotic, suicidal, and depressed children in the schools. They attribute some of the problem to a decrease in the use of residential treatment facilities and hospitalizations by the BHOs.

According to many school health advocates, complicating the situation is the general dearth of psychiatric services for children in the State. Initially, many child psychiatrists signed on with the Salud! program; however, low reimbursement rates and limited service

definitions have gradually led to a decline in the number of psychiatrists willing to treat Medicaid recipients. As a result, school providers have found it difficult to refer children out for services beyond the scope of the school-based heath center.

C. Access

In theory, under the managed care mental health pilot, SBHC services are not supposed to be based on the types of reimbursement available for treatment. In practice, however, respondents overwhelmingly indicated that the sponsoring organizations' perception of their ability to obtain reimbursement profoundly affects the types of services provided to certain children. On the basis of previous experience with the plans, providers are aware of the services that are likely to be authorized. The time associated with the prior authorization process for some plans has led some providers to initiate only treatments they are fairly confident will result in reimbursement. This was particularly true for the medications prescribed by psychiatrists in each of the centers. In this sense, providers felt that they were moving away from diagnosis-based treatment.

Additionally, providers expressed frustration with the prior authorization process. They found the systems are difficult to navigate; the avenues through which authorization could be obtained were limited. The different definitions of medical necessity in each plan complicate the process still further. However, UNM providers have found placing children in UNM facilities and obtaining authorization for UNM services comparatively easier than accessing those services for children enrolled in the Options/Presbyterian plan, for which UNM does not have contracts. This may be because UNM providers are better acquainted with the UNM system and have contacts in the various departments to ease these processes.

Overall, providers feel that under the pilot they have less time to treat children. Although providers are required to spend a certain percentage of their time seeing patients, with the level of paperwork required to gain prior authorization, they report that it is difficult to find the time to do both jobs. In fact, one school-based health center reported that it closed its doors and sent waiting children away twice in one semester because of cases that required all members of the staff to either treat the child or make phone calls to get the child admitted somewhere for further treatment. In efforts to be more available to children, some providers ignore insurance status and paperwork, rendering many of their services unreimbursable.

Although frustrated, providers indicated that they are adapting to the managed care pilot. As mentioned above, they sometimes rely on school resources to help children gain access to treatment. Additionally, to expedite the process, providers at Albuquerque High School have begun to heavily document their evaluations, making it more difficult for a health plan to turn a child away. In addition, providers are becoming accustomed to calling admitting officers to follow up on cases and to advocate for their patients.

D. Contracting

According to SBHC and State representatives, working out the terms of the contract or requirements has been a fairly smooth process. Program administrators indicated that meetings took place on a regular basis to negotiate the terms of the contracts and to make modifications as necessary. In fact,

several individuals interviewed mentioned meetings that were taking place to resolve issues pertaining to prior authorization.

Nevertheless, some problems have been reported. In addition to high turnover rates, interest in BHO participation in the pilot has been uneven. Since participation in the pilot is not mandated, BHOs that have a fairly strong provider network or that do not believe the pilot to be in their best interest financially have been reluctant to work with the centers and their satellite providers to resolve administrative issues. Additionally, because contracts are negotiated between sponsoring organizations and BHOs, the BHOs are often too far removed from the process to realize some of the difficulties faced by SBHCs.

E. Financing

Project administrators indicated that, overall, managed care has not radically altered the types of funding used to support school-based mental health services. Complicated reimbursement processes and a high BHO claims denial rate have limited resources obtained through Medicaid reimbursement. As a result, the pilot still relies heavily on grants and State funding to support the provision of services.

Sponsoring organizations appear to have incurred high costs under the new system. According to providers, UNM has been "running in the red" since Medicaid managed care was implemented, running a $1.5 to $3 million deficit in the past 2 years for mental health services provided in the schools and through its other community-based clinics. Providers indicated that low reimbursement rates have contributed to the situation. Before Salud! program, UNM's school-based mental health program was expanding; providers indicated that Medicaid reimbursement was less complicated and more predictable at that time. As a result of financial constraints, UNM has been unable to further expand its mental health program, despite requests from schools in the Albuquerque area.

IV. Conclusion

New Mexico's Medicaid managed care pilot for school-based mental health services is still in its infancy. At the time of initial interviews, the program was less than a year old; thus, many of the programmatic and administrative details are still being discussed. Environmental changes around the delivery and financing of health care services have paralleled and complicated development of the pilot. The statewide Medicaid managed care program was in place for less than 6 months before planning for the pilot began. The short lead-in period for both initiatives has left little opportunity for providers to adapt to their new environment.

Despite these challenges, most administrators of the pilot at both the State and local levels believe that the mental health system and public health workers have made great strides to integrate school-based mental health into the statewide Medicaid managed care program. Although the operation of the program has been fraught with challenges, they are working hard to overcome the growing pains associated with such a young program. They are hopeful that ongoing discussion with the BHOs about prior authorization, claims submission, and referral will improve upon the provision of care during the first year of operation.

Reflecting this optimism, efforts have already been undertaken to expand the program beyond the five pilot sites. On the basis

of the high number of school children who are Medicaid-eligible and in need of mental health services, the Human Services Department began funding additional pilot sites for the 1999–2000 academic year.

Appendix B-2
Baltimore, Maryland

I. Introduction

The Baltimore City Health Department (BCHD) has a unique and close working relationship with the independent local mental health authority, the Baltimore Mental Health Systems (BMHS), for they were both established in mid-1980s. BMHS manages, coordinates service, and oversees all the city's mental health providers. Today, BMHS works with BHCD to fully integrate mental health care in its school-based health centers (SBHCs) under the State's managed care plan. This case study focuses on the city of Baltimore, Maryland, and two SBHCs within the city limits. The first section of the study reviews structural components of the program, and the second section describes participants' experience with the program before and after introduction of Medicaid managed care. This review incorporates the perspectives of State and local officials, mental and physical health care providers, and numerous school staff, including principals, teachers, guidance counselors, and school nurses.

II. Structure

A. Background

Baltimore, Maryland, has one of the largest (46 SBHCs) and longest-running SBHC programs in the country that provides mental health services. The oldest center opened its doors in the mid-1980s. During the 1997–98 school year, students at these centers used mental health services more than other types of services. During this same period, a total of 2,860 students in 53 schools were referred for mental health services.

Two SBHC models operate in the Baltimore City Public School System (BCPSS)[1]—a full-service SBHC providing mental health care and a separate, freestanding mental health provider. The Baltimore City Health Department sponsors mental health services in 80 different schools; 15 of them are part of comprehensive SBHCs. The 15 SBHCs are located in 7 high schools, 3 middle schools, 1 middle/high school, 3 elementary schools, and 1 K–8 school. The remaining schools have community-based mental health providers who come into the schools on a periodic basis to provide services to students.

School-based mental health services, provided through a collaboration among BCPSS and eight community-based mental health agencies, are available to all students in regular education. These services address underlying emotional and behavioral concerns, thereby enabling students to participate in academic instruction. The schools themselves do not play active administrative or financing roles in the SBHC; however, a school may provide the SBHC with in-kind support and clinic space.

Before the implementation of Medicaid managed care in 1997, SBHCs in Maryland billed for provided services under a fee-for-service arrangement with little bureaucracy and limited paperwork. SBHC providers served all children in the school, regardless of their insurance status, relying heavily on

[1] The SBHCs in the Baltimore City Public School system are a subset of the 46 SBHCs in Baltimore.

private grants and financial support from the Baltimore City Health Department and the Baltimore Public School Board. However, with the State's move to managed care, SBHCs were deemed essential providers under the Medicaid waiver. Accessing these funds has meant observing all the requirement complexities of Maryland's Medicaid waiver.

Since Maryland has a partial carve-out system for mental health under its Medicaid managed care waiver, mental health services are provided by both managed care organizations (MCOs) and the Specialty Mental Health System (SMHS). The SMHS is administered by the Mental Hygiene Administration (MHA) in conjunction with 19 local Core Service Agencies (CSAs) and a behavioral health company, Maryland Health Partners (MHP), that assists them with administration and monitoring of the SMHS.

The roles of agencies involved in the delivery of school-based mental health care are described below:

Mental Hygiene Administration—The MHA administers the SMHS, along with the 19 CSAs. The MHA is responsible for overseeing all publicly funded mental health services and thus monitors CSA performance.

Core Service Agencies—CSAs are locally based government or private nonprofit entities that fund community-based mental health services on behalf of the State. Under the carve-out, CSAs continue their role as local governance entities.

Baltimore Mental Health Systems, Inc.—BMHS is a public nonprofit CSA that acts as manager, coordinator, and local authority for mental health services in Baltimore. It is the only CSA in Baltimore. BMHS is not a direct service provider but oversees the provision of mental health services in seven catchment areas throughout the city. BMHS was established in 1986 by the Baltimore City Health Department with a 5-year, $2.5 million grant from the Robert Wood Johnson Foundation Program on Chronic Mental Illness.

Maryland Health Partners—MHP is made up of private, competitively procured behavioral managed care organizations retained as an administrative service organization (ASO) to provide extensive administrative and monitoring services.

Community Mental Health Provider Agencies (sponsoring agencies/MHPAs)—Baltimore City Public Schools are served by 13 community mental health providers that employ and station mental health clinicians in Baltimore city schools.

B. Administration

Mental health programs integrated into SBHCs do not operate in the same way as freestanding mental health programs. Typically, SBHCs with mental health services include multidisciplinary health professional staff to address the varied needs of the school population. The mental health professionals can rely on the SBHC staff for issues related to students' physical health. Providers in schools with freestanding mental health services usually rely on school nurses to address the physical health needs of their students.

This case study includes both models—Harford Heights Elementary School, which has a full-service SBHC, and Winston Middle School, which has a freestanding mental health program. Harford Heights has roughly 1,700 students enrolled in kindergarten through eighth grade. Winston has a relatively small student population of about

600. Winston's school nurse attends to students' physical health needs; one full-time mental health clinician, employed by a mental health provider agency, attends to students' mental health issues. In contrast, the student population at Harford Heights is substantially poorer: more than half of its students receive free or reduced-cost lunches. Since the school is fairly large, the sponsoring agency has allocated two-and-a-half full-time mental health clinicians for Harford Heights' students.

The sponsoring provider agencies administer these two programs in very similar ways. The North Baltimore Center provides Winston Middle School with a mental health clinician and collects provider reimbursement claims, submitting them to the Baltimore Public School System, Office of Third-Party Billing (OTB). The North Baltimore Center also facilitates prior authorization requests and treatment plan submissions. Similarly, the East Baltimore Mental Health Partnership provides Harford Heights with mental health clinicians and assistance with prior authorization, treatment plans, and reimbursement documentation.

C. Coverage

Harford Heights, which is typical of other SBHCs in Baltimore, and Winston Middle School provide physical and mental health services to students and members of their families. Mental health and substance abuse services are provided on-site or through referrals. SBHCs provide mental health assessment, treatment, referral, and crisis intervention. Services include individual mental health assessment, treatment, and follow-up; alcohol or other substance abuse assessment, counseling, and referral; suicide prevention; crisis intervention; group and family counseling; and psychiatric evaluation and treatment.

A student can be referred to the mental health provider in the school or SBHC in a variety of ways. In many instances, teachers identify children in their classrooms who may benefit from a visit with the mental health provider(s). School counselors, nurses, and other school staff may use the mental health provider when they believe that a student has a problem at school or at home. For schools with SBHCs, mental health needs are sometimes identified when a student enters the SBHC for physical health services. Additionally, students refer themselves or their friends to the mental health provider.

D. Contracting

Baltimore SBHCs do not contract directly with managed care organizations; Maryland Health Partners does not have formal contracts with either SBHC staff or individual mental health clinicians. Rather, it contracts with community mental health provider agencies that in turn supply mental health clinicians to the schools. The contracts stipulate procedures for reimbursement, prior authorization, and documentation of treatment plans.

Mental health providers in Baltimore city schools must submit prior authorization forms and treatment plans to MHP for students they believe will require more than 12 visits. Typically, 12 visits will be approved automatically. A treatment plan must be completed by no later than the eighth visit and must be timed at least 3 weeks prior to the twelfth visit. To gain authorization for therapy sessions beyond 12 visits, the student must have a *Diagnostic and Statistical Manual* (DSM-IV) diagnosis. Depending on

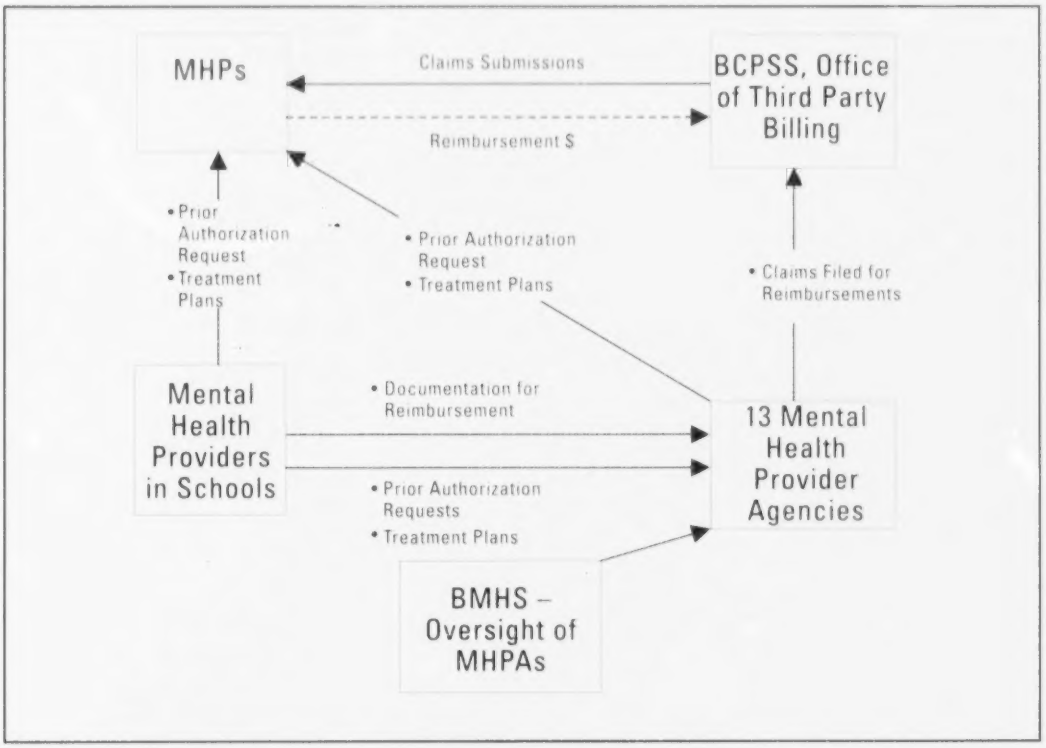
the agreement between the school and the sponsoring provider agency, some provider agencies act as central depositories for their schools and will forward treatment plans and prior authorizations to MHP after collecting them from the schools. Other sponsoring provider agencies require that their clinicians submit the proper documentation directly to MHP. However, all mental health clinicians in schools are required to submit reimbursement forms to their respective provider agencies. The provider agencies are then responsible for processing those claims to the OTB in the BCPSS. The OTB submits reimbursement claims to MHP; reimbursement dollars are funneled back to the OTB (Exhibit B-2-1).

E. Financing

On July 1, 1997, with the implementation of the Medicaid managed care waiver, Medicaid funding for specialty mental health was joined with the resources of MHA to provide a single funding stream to Baltimore Mental Health Systems (and its mental health provider agencies) to provide Medicaid mental health services.

The MHA combines Medicaid with its own resources (State mental health grant funds and State hospital funds) and allocates sponsoring mental health providers a global budget based on historical rates of use. MHP collects reimbursement claims from the BCPSS OTB and processes them for collection. MHP is paid a set fee for its servic-

Exhibit B-2-1: Flow of Paperwork for Reimbursements and Prior Authorizations



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es; reimbursement dollars are then sent to the OTB, which pays sponsoring provider agencies on a fee-for-service basis. The provider agencies, in turn, employ and pay mental health providers on a salary basis (Exhibit B-2-1).

The school board allocates $1.6 million for mental health programs for students who do not receive services under special education. The $1.6 million is then directed to sponsoring provider agencies that provide mental health services to students in 53 BCPSS schools. In addition, during the 1997–98 school year, State and Federal funds allocated through BMHS provided $1,105,200 to supplement funding provided by the BCPSS in many of the 53 schools and to fund mental health services in 10 additional schools (Table B-2-1).

Exhibit B-2-2 illustrates the flow of funds among the different actors in the financing and reimbursements of school-based mental health services. Sponsoring mental health provider agencies receive grant money from Baltimore Mental Health Systems, Inc., and an allocation from the Baltimore City Public School System to place mental health clinicians in the schools. Sponsoring provider agencies in turn collect reimbursement information from their clinicians and forward it to the OTB, which then submits claims information to MHP for treatment provided to eligible individuals. Reimbursements are paid directly to the OTB, and are used to offset the $1.6 million the BCPSS allocates to provider agencies to provide mental health services in the schools.

For OTB to gain reimbursement for services provided to Medicaid-eligible students in regular education, several steps are necessary. First, the mental health professional providing the service must be either one of the following:

1. Functioning as an employee of a licensed outpatient medical health center (OMHC) that follows Code of Maryland (COMAR) regulations and is paneled with MHP

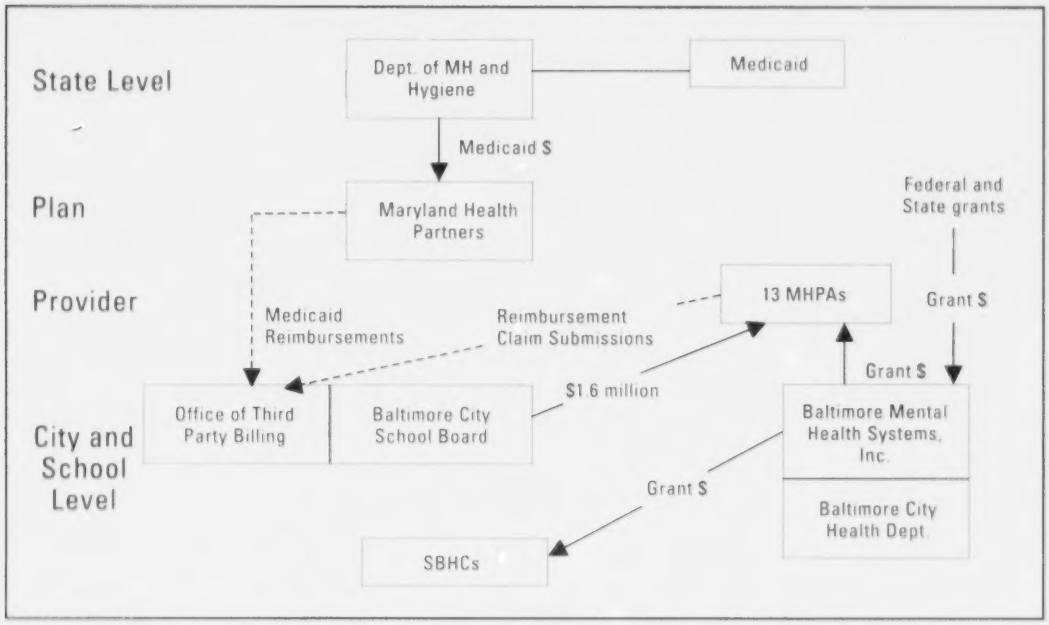
2. An individually licensed mental health professional who has a Medicaid provider number and is paneled as an individual provider with MHP

Before billing can begin, each student for whom mental health services are provided must be registered with MHP. A DSM-IV diagnosis must be entered on the encounter form. If the student does not have a diagnosable mental health condition, the student cannot be registered with MHP, nor can the treatment costs be reimbursed.

Table B-2-1. Funding for School-Based Mental Health Services in Baltimore

Funding Source	*% of Total Budget to Fund MH Services in 63 BCPS Schools*	*Amount of Funding*
BCPSS	57	$1,600,000
State and Federal mental health funds allocated through Baltimore Mental Health Systems, Inc.	40	$1,105,200
In-kind services from five of the mental health agencies receiving BCPSS contracts	3	$86,600
Total	100	$2,791,800

Exhibit B-2-2: Flow of Dollars from the State Level to the City and School Level



A treatment plan must be completed and submitted to MHP no later that the eighth session for any student who (1) has a DSM-IV diagnosable condition and (2) is likely to require more than 12 sessions with a mental health clinician. MHP requires that the treatment plan be mailed 3 weeks before the twelfth visit.

After the required treatment plan has been submitted and reviewed by MHP, a treatment authorization form is mailed to the provider. It is the responsibility of the mental health clinician to track the number of sessions as well as the start and end dates on the approvals. In this way, the clinician can ensure that updated treatment plans for any additional sessions needed are submitted in a timely fashion. Also, if the student is receiving services from another community provider, those services count against the allotted 12 sessions.

III. Experiences

A. Administration

According to Baltimore city officials, the administration of the program runs relatively smoothly, despite the complexity of the claims and documentation process. Administrators reported that a positive outgrowth of the increased documentation is the collection of school-health-related outcome data. Since providers were not required to submit treatment plans or prior authorization forms before managed care, valuable data on treatments provided and client demographics were lost. The increased documentation of school mental health activity increases provider accountability and assists in strategic management of the program.

However, administrators of the program stressed that Baltimore is unique given the role of its local mental health authority

(BMHS) in advocating for appropriate mental health services. BMHS has continued to resolve and fill in treatment gaps when they occur. For instance, BMHS recently implemented a prevention program in which mental health clinicians can bill for their time to community prevention and support activities. By using State-only Medicaid money, the BCPSS and BMHS have created service codes for preventive sessions, including mental health education, conflict resolution, anger management, after-school clubs, and self-esteem issues. Clinicians can bill using these service codes after submitting a proposal to their sponsoring mental health provider agencies.

B. Coverage and Access

Mental health issues are consistently the foremost reason for student to visits their SBHC or mental health clinician. During the 1997–98 school year, over 20,000 individual sessions and more than 8,800 group contacts were provided. Reported teacher contacts totaled more than 8,000, and over 4,000 parent contacts were made during the course of the school year.

Despite the growing need for services, respondents indicated that introduction of Medicaid managed care in the school-based environment has reduced the time mental health clinicians have available to treat patients. The administrative work that accompanies billing and registration requirements is both cumbersome and time-consuming, according to school mental health clinicians. Providers must now keep a record of how many sessions are authorized, how many have been used, and for whom they need to request more sessions. If a child requires more sessions, treatment plans have to be written or adjusted.

Two reasons underlie why mental health clinicians are under pressure to treat only students eligible for Medicaid and the Child Health Insurance Program:

1. Sponsoring agencies are strongly encouraged to replace the $1.6 million allocated from State-only educational funds with Federal Medicaid dollars.
2. Sponsoring agencies want to avoid the cumbersome and idiosyncratic reimbursement processes required by private insurers.

Unintended consequences of these unstated policies are that few non-Medicaid-eligible students receive therapy; group rather than individual therapy is offered; and less time is available for prevention services. Compounding the pressure on therapists is the growing number of students with more serious mental health problems. Last year, one school had nine children with suicidal ideation and many more with depression. Many clinicians and school staff are seeing more and more children in need of mental health services.

C. Financing

The Baltimore Public School System, Office of Third Party Billing, began seeking reimbursement in July 1998. The office set a target of $350,000, based on the amount collected in the preceding year under the nonmanaged fee-for-services system. To date, this goal has not been met.

In fiscal year 1999, claims totaling approximately $156,000 were submitted for Medicaid reimbursement, but only $82,000 was actually recovered. Clinicians are not submitting all eligible claims because of the tremendous paper burden.

Issues of stigma have also affected the claims submission process. MHP requires a DSM-IV diagnosis before services can be

authorized for reimbursement. Many clinicians are concerned about the possibility of stigmatizing students by assigning a DSM-IV diagnosis. Therefore, clinicians will refrain from assigning such a diagnosis to a student (but continue to provide services), making it impossible to obtain reimbursement for services rendered. Of the approximately 2,700 students seen in 1999, 1,000 were given DSM-IV diagnoses.

IV. Conclusion

Though Baltimore is unique in the sense that the school board provides a large portion of the funding for mental health services, the city's desire to recover reimbursements as they did before managed care requires clinicians to adjust the services they provide and to make decisions about who can receive those services. This adjustment in services usually leads to less one-on-one treatment and allows little flexibility in treating students not covered under Medicaid.

Although Medicaid managed care has shifted the ways in which services are provided, organizations such as Baltimore Mental Health Systems, Inc., are instrumental in resolving billing issues and filling some of the gaps not provided for under the current system. BMHS's prevention program is unique, providing clinicians with service codes to bill for mental health education and illness prevention. Administrators hope that these additional services will provide greater flexibility and help ease some of the pressures that clinicians incur surrounding billing and reimbursement.

Appendix B-3
New London/Groton, Connecticut

I. Introduction

In 1985, with an initial grant of $50,000, Connecticut opened its first Department of Public Health-funded SBHC in the city of Bridgeport to provide needed medical services to underserved children. Today, Connecticut has the sixth-largest SBHC program in the Nation, with 51 SBHCs operating throughout the State on a budget of more than $5 million. Unique to the Connecticut model are regulatory requirements mandating formation of contracts between SBHCs and Medicaid managed care contractors. Since 1997, SBHCs have been considered "ancillary providers" within the managed care network and are reimbursed on a fee-for-service basis. This case study focuses on the communities of New London and Groton and their experiences under Medicaid managed care. Both communities are served by the Child and Family Agency (CFA) of Southeastern Connecticut, Inc., which has a distinguished history of providing mental health services in the region. The first section of the study reviews the structure of the program, while the second section describes participant experiences with the program before and after introduction of Medicaid managed care. This review incorporates the perspectives of State and local officials, mental health and physical health care providers, and numerous school staff, including principals, teachers, guidance counselors, and school nurses.

II. Structure

A. Background

Of Connecticut's 51 SBHCs, the State Department of Public Health (DPH) funds 46 centers in 15 cities.* Eighteen SBHCs are located in high schools, 12 in middle schools, 9 in elementary schools, 6 in K–8 schools, and 1 in an early childhood center. Statewide, 26,204 students are enrolled in DPH-funded school health centers.

Under the original model for school-based health care developed by the DPH, SBHCs were not required to seek reimbursement for Medicaid-eligible clients. By 1993, however, DPH found that State grants could not support 100 percent of the costs incurred by the centers. With the introduction of Medicaid managed care in 1997, in an effort to establish additional revenue, the decision was made to require SBHCs to work with the Department of Social Services (DSS–Medicaid) to seek reimbursement.

SBHC reimbursement for individuals eligible for Medicaid is managed under the current Medicaid managed care contract. Connecticut's DSS operates a Medicaid managed care program—Connecticut Access—that includes physical health, mental health, and substance abuse services under a 1915(b) Medicaid waiver. DSS contracts with seven private, for-profit HMOs and two federally qualified health centers on a fully capitated basis. Four plans with contracts in Connecticut are required by DSS to use SBHCs and child guidance clinics as part of the traditional community provider network.

In the New London and Groton region, there are two models of SBHCs typical of those found throughout the State—a full-service SBHC providing mental health care in the school and a school-linked health center that operates in the community near the school. SBHCs selected for the site visit were both full-service SBHCs in the schools, providing physical and mental health services through a multidisciplinary team of providers.

B. Administration

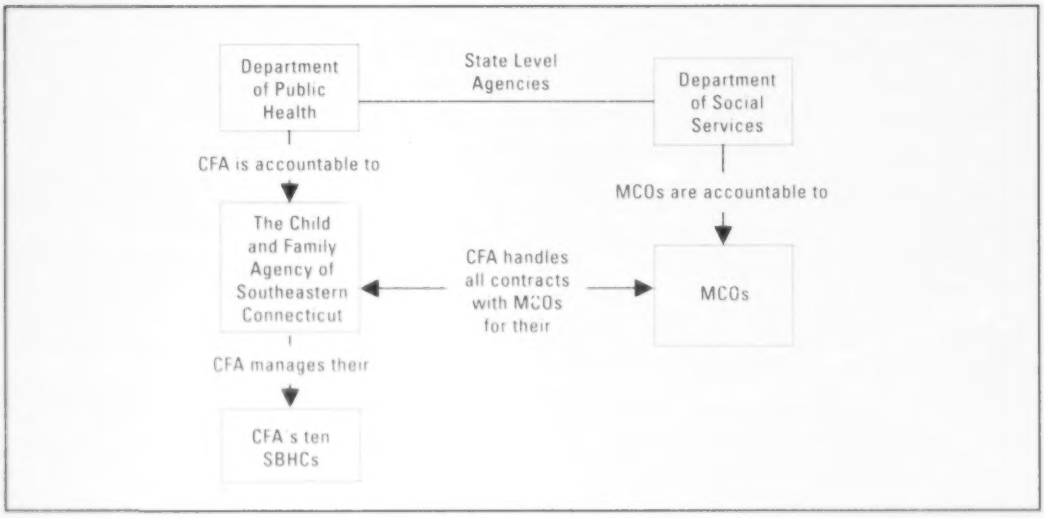
Two State organizations have oversight responsibility for financing and delivery of SBHC services. SBHCs in Connecticut are accountable to the DPH, and Medicaid managed care organizations (MCOs) that contract with SBHCs are governed by the State DSS. The DPH and the DSS communicate about the feedback they receive from schools regarding managed care issues, and jointly mediate relationships between MCOs and SBHCs.

In southeastern Connecticut, the Child and Family Agency manages 10 SBHCs and performs contracting, billing, and other administrative functions. Since CFA is the sponsoring organization for 10 SBHCs in the region, they are also required to meet Department of Public Health reimbursement and administrative requirements (see Exhibit B-3-1).

CFA receives DPH grants for SBHCs operating in southeastern Connecticut. It also negotiates and maintains contracts with MCOs on behalf of SBHCs in the region. Since the DPH requires SBHCs to bill Medicaid to obtain funding, CFA coordinates the billing for its 10 schools, negotiating reimbursement and prior authorization procedures with its partner MCOs. CFA in turn employs and stations mental health professionals in the SBHCs and school-linked

* Non-DPH-funded schools are financed through private donations and institutional partners.

Exhibit B-3-1: CFA Structure


Department of Public Health
State Level Agencies
Department of Social Services
CFA is accountable to
MCOs are accountable to
The Child and Family Agency of Southeastern Connecticut
CFA handles all contracts with MCOs for their
MCOs
CFA manages their
CFA's ten SBHCs

health centers. Although these clinicians work with school nurses and counselors, they typically regard themselves as guests in the schools. The role of the schools is usually limited to providing in-kind support such as clinic space or administrative support.

C. Coverage and Access

Connecticut's SBHCs are comprehensive primary care facilities located within schools or on school grounds and serving youth enrolled in prekindergarten through twelfth grade. They are staffed by multidisciplinary teams of pediatric and adolescent health specialists, including nurse practitioners, physician assistants, social workers, doctors, and, in some cases, dentists and dental hygienists. SBHC services include treatment of acute injury and illness; routine checkup; physical examination and health screening; immunization; dispensing of prescriptions and medications; diagnosis and treatment of sexually transmitted disease; oral health screening; and, in some sites, full dental care, crisis intervention, and individual, family, and group counseling.

CFA's SBHCs in the southeastern region of the State offer approximately the same physical health services as all Connecticut SBHCs, as well as the following mental health services:

- **Parent-Child Counseling**—includes family therapy, play therapy, and group and individual counseling to help strengthen the family
- **Victimization Counseling**—for young children who have experienced sexual or physical abuse, and their families
- **Home-Based Family Preservation and Reunification Services**—designed to resolve situations in which one or more children are in imminent danger of being placed in State care
- **Diagnostic and Evaluation Services**—provide clients with a full range of psychiatric, psychological, and psychosocial assessment services
- **Young Parents Program**—provides social service, physical, and mental health care to adolescent mothers enrolled in the school system and to their infants

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Students gain access to SBHC services in a variety of ways. Teachers, counselors, school nurses, coaches, and parents may refer students to the SBHC. At the Norwich Free Academy in New London, for example, teachers frequently refer those students they believe may be having problems at school or at home to the mental health providers in the SBHC. Self-referrals and word-of-mouth referrals between students also occur commonly.

Mental health issues are a significant part of student visits to health centers. Statewide, 33 percent of all student visits to the centers are for mental health or substance-abuse-related services. A 1997-98 annual report from the Connecticut Department of Public Health documented 73,836 visits to SBHCs, of which 24,523 were related to mental health and substance abuse issues. In the southeastern region of the State, the demand for such services is even greater. More then 40 percent of all student SBHC visits in the New London and Groton areas are related to mental health or substance abuse.

Once a student is seen by a mental health provider in the SBHC, that student is medically assessed and can be seen by a mental health clinician up to five times. If the student needs services beyond five visits, the MCOs require referral to community providers in the MCO's network. SBHC staff refer students to community providers if they believe individuals require services that they cannot provide.

D. Contracting

Since Medicaid managed care began in Connecticut in 1997, SBHCs have been required by the Department of Public Health to contract with MCOs to continue receiving grants allocated by the DPH. Likewise, MCOs are required to include SBHCs in their provider network as a condition of contracts with the State Medicaid office. All SBHCs in Connecticut have at least one contract covering mental health services. Acting as liaison in the contract negotiation process, both the DPH and the DSS are in constant communication with one another, monitoring feedback from SBHCs and MCOs about difficulties experienced in contracting and reimbursement. The two departments may also facilitate negotiations to ensure a fair and reasonable process.

Statewide, nine SBHC sponsoring organizations have contracts with Preferred One, six have contracts with Kaiser that include mental health services, three have contracts with Pro Behavioral, three with CMG, and two with Magellan (formerly Merit). Five SBHC sponsoring organizations previously had contracts with Value Behavioral Health; however, because Value Behavioral is no longer a vendor in Connecticut, these SBHCs now contract with a new vendor.

Although contract requirements differ for each MCO, prior authorization requirements for treating students at SBHCs generally are similar to the requirements for more traditional outpatient clinics:

- Usually one or two sessions are reimbursed by the MCO without prior authorization; up to five visits are authorized before a student must be referred to community providers.
- The school mental health staff must request authorization for additional sessions in advance, by phone or in writing.

Several SBHCs are required to have primary care physician involvement in the authorization of behavioral health services. One SBHC noted that its behavioral health

contract permits two sessions before authorization, after which a client's primary care physician must be contacted for referral.

E. Financing

The Connecticut Department of Public Health makes grants to all SBHCs in Connecticut through a noncompetitive process as long as they are in compliance with DPH standards and State funding is available. Funding for school-based health has grown from $100,000 in 1986 to $5 million in 1998. In the 1997–98 school year, $288,096 came from Title V MCH Block Grant, $3,837,129 from the State General Fund, $725,270 from the Robert Wood Johnson Foundation, and $104,122 from the Safe and Drug-Free Schools initiative.

CFA receives a portion of these resources for its SBHCs and has an endowment producing an annual budget of $3.5 million. The endowment supplements the costs of providing care if costs exceed revenues available for a given year.

III. Experiences

A. Access and Utilization

The kinds of mental health services available in southeastern Connecticut's SBHCs have been unchanged since the introduction of contractual arrangements with Medicaid managed care plans. Respondents indicated that although not all mental health services provided to Medicaid-eligible children in the centers are reimburseable under contract, the SBHCs have been able to offer the same services that existed before the implementation of the contract. Services outside the scope of the Medicaid managed care contract continue to be funded through Federal and State grants.

However, contracting with Medicaid managed care plans has affected the amount of mental health services available to students in the centers sponsored by CFA. Overall, respondents indicated that they have less time available to treat students who are in need of mental health services. Two factors have contributed to this decline: (1) the amount of time that must be devoted to prior authorization procedures and (2) an increase in the number of students who need more intensive forms of mental health care.

To be eligible for reimbursement, mental health services must be authorized by the managed care plan before treatment commences. Unlike physical health care services, mental health services require that prior authorization be obtained by a physician. According to respondents, this process often creates a backlog of paperwork and phone calls for the part-time physician on staff at the center. In some instances, physicians are "on hold" with the managed care organization for up to an hour trying to obtain authorization for a single client, decreasing the amount of time available for seeing patients. Overall, estimates of time required varied from 30 minutes per client for an initial request to 1 hour for treatments extending beyond the initial authorization.

Prior authorization procedures have also affected the amount of care available to patients. Some clinicians reported finding that the number of sessions authorized by plans limits therapy. Clients may not receive the full amount of time in therapy they would have were they seeing a community provider. Clinicians noted that students are seen for several 20-minute sessions to mini-

mize the loss of class time. Thus, two or three sessions may be needed to provide the same service that ordinarily would be provided in a 1-hour session in an out-of-school setting. Since authorizations are for sessions, not time with a client, only limited services can be provided under this arrangement.

Access to mental health care in the SBHC is also compromised by the increasing time clinicians spend treating children with severe emotional disturbances. Clinicians find that they sometimes spend a full day or several days with students in crisis. For instance, an SBHC staff member once identified a student with suicidal ideation and stayed with her for an entire day before the SBHC located services outside the school. When such situations occur, the clinician's caseload gets pushed back and other students' sessions must be rescheduled or canceled.

SBHC staff in New London and Groton reported an increase in students who require more intensive services. Because of the dearth of providers in the community, staff reported having to treat serious cases to the best of their ability in the health center. Barriers to referrals for students in need of intensive services and hospitalization were reported. For example, one student at the Norwich Free Academy displayed signs of serious depression, leading SBHC staff to take the student to the local emergency room. The emergency room physician called eight different hospitals to arrange a psychiatric bed but couldn't find one. The physician tried to admit the student into a partial hospitalization program but was again unsuccessful. Eventually, a hospital in Hartford, more than an hour away, was found for the student. SBHC staff also indicated that even when referred to an outside agency, students may wait 4 to 6 weeks for medication.

B. Contracting

Statewide, negotiations establishing contracts between sponsoring organizations (on behalf of SBHCs) and managed care companies were difficult. The majority of disagreements centered on the list of services to be provided and the prior authorization process. Representatives for SBHCs objected to tying insurance status or the ability to recover dollars to the services that would be covered in the centers. They also felt that managed care companies did not understand the SBHC model and philosophy. As a result, the negotiation process in some areas of the State was quite lengthy, according to DPH officials, taking up to 2 years to solidify the contracts in some regions.

These experiences, however, do not reflect the negotiation process that took place between CFA and managed care organizations serving southeastern Connecticut. Officials from CFA indicated that their previous experience with managed care organizations prepared them to better resolve disputes about service definitions and prior authorization requirements.

Confidentiality is one area that continues to concern both CFA representatives and clinicians. Because the MCO requires that a student's primary care physician be involved in the prior authorization process, physical health care providers routinely have access to patients' mental health records. Clinicians reported that some students have refused services to avoid the involvement of their family physician.

C. Financing

The vast majority of SBHC mental health services are funded by grants from public and private sources. When Medicaid managed care became prevalent, SBHCs were expected to enter managed care provider networks and bill for reimbursement, a shift in funding for SBHCs. However, despite contracting requirements, SBHCs across the State reported severe drops in Medicaid revenue under managed care. Statewide, the highest estimate of costs recovered through Medicaid managed care for mental health care is 5 percent of costs incurred. One year after the implementation of Medicaid managed care, 19 SBHCs responding to a Department of Public Health survey had signed contracts with at least 1 plan; only 12 were billing. Even fewer were billing for mental health services.

SBHCs in southeastern Connecticut indicated that they see very little value in submitting claims to MCOs. A high denial rate, the cumbersome nature of the process, and CFA's heavy reliance on public and private grants to supplement administrative and treatment expenses have influenced CFA's decision not to submit all claims for reimbursement. Typically, CFA recovers about $35,000 in Medicaid reimbursements. This amount barely covers the administrative costs the organization has incurred, including a $25,000 annual salary for extra staff to offset the paper burden of billing Medicaid for reimbursements. Overall, CFA respondents question the value of billing Medicaid, as significant revenues are not realized. The CFA reported that it makes the effort to bill just to continue receiving DPH grants, but it is not aggressive in this pursuit.

IV. Conclusion

Because of CFA's extensive experience in mental health and prior experience contracting with MCOs for services, SBHCs in New London and Groton have been somewhat immune to the effects of Medicaid managed care. CFA SBHCs also have a financial advantage, relative to other centers, because of CFA's rich endowment and private supporters. Its financial strength allows CFA to be more flexible and therefore less dependent on reimbursement from Medicaid.

Nevertheless, CFA SBHCs still face some administrative problems that have compromised students' access to mental health services. Clinicians indicated that the increased paperwork burden imposed by MCOs limits the time available to attend to students' mental health needs. Because the prior authorization process is cumbersome, a significant amount of clinicians' time is taken up with phone calls to the MCO and paperwork. Additionally, several environmental issues affect the access to mental health services for underserved students in New London and Groton. Respondents are concerned with the high number of students they treat who require access to more intensive services, and the lack of available resources in the community to fulfill this need.

To address these issues, respondents suggested streamlining prior authorization by (1) removing the requirement that the primary care physician request authorization and (2) making the phone-in process easier by limiting wait times for approval. Clinicians believed that these changes would allow them to identify and treat more students in a more efficient manner.

VIII. Appendix C: References

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